Return Application With Check Payable To:
NH Board of Pharmacy

Annual Licensing Fee:
$250

State of New Hampshire
Board of Pharmacy

57 Regional Drive
Concord, NH 03301-8518
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy

Board Use Only (Do Not Write In This Box)

Check #:_____

July 1, 2008 – June 30, 2009
Registration Period

LIMITED RETAIL DRUG DISTRIBUTOR
METHADONE MAINTENANCE / DETOXIFICATION FACILITY

(NH Department of Health and Human Services Certified Alcohol / Drug Disorder Treatment Provider)

Clinic Name & Address: ***(Actual Licensed Location)***

_____
Clinic Name

_____
Street Address

_____
City *State* *Zip Code*

Telephone:	Fax:	DEA Registration # **(Attach Copy)**

Parent Company (If Applicable):

Controlled Substances On Site: ☐ Methadone ☐ LAAM ☐ Buprenorphine	Current NH HHS Certified Drug Treatment Provider Certificate #: **(Attach Copy)**	Security: ☐ Audible ☐ Motion Signal To:

Applicant's Proposed Drug Activity: **(To bona fide patients of clinic only)**
☐ Administer ☐ Dispense
"Take Home" Available: ☐ Methadone ☐ Buprenorphine

Drug Supply: ☐Bulk ☐ Prepackaged*
*Prepackaged By: _____
Location:_____

Name Of Owner(s): (Indicate Individual, Partners, Etc. - If Corporation, Show Title Of Officers) Attach Additional Sheet If Necessary

Name	Address	Title
Name	Address	Title

Has registration or licensure granted to the applicant by any state or federal agency ever been suspended or revoked? ☐ Yes ☐ No
(If "yes", attach a detailed description).

Provide the information below for the person responsible for the operation of the clinic: (The permit & future renewals will be directed to this person)

Name: Title: Tel. #:

Business Mailing Address:

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Provide name(s) of person(s) in charge of drug purchasing, dispensing records and security. (Use Reverse Side if Necessary)

Medical Director:

Name	Address	Telephone Number

ALL QUESTIONS MUST BE ANSWERED AND COPIES ATTACHED OF DEA REGISTRATION & NH HEALTH & HUMAN SERVICES CERTIFIED DRUG TREATMENT PROVIDER CERTIFICATE

APPLICATION CONTINUED ON OTHER SIDE ⇨- ⇨- ⇨- ⇨- ⇨- ⇨

Practitioners: (Use Reverse Side If Necessary)

Name:	Title:	Name:	Title:

Consultant Pharmacist:

Name	**Consultant's Signature** (Applications without consultant's signature will be returned unprocessed)	NH License No.

Declaration And Signature By Clinic Representative:

I declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the permit herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State. To the best of my knowledge, myself nor any of the employees, listed on this application, have been arrested, investigated for, charged with, convicted of, sentenced, entered a plea of non contendere, or entered into any other legal agreements for any criminal offense in any state, territory or possession of the United States or by the federal government.

Signature: _____ Title: _____ Date: _____

(Responsible Party) ***(Indicate whether owner, partner, or officer of corporation)***

** THE LICENSEE SHALL NOTIFY THE BOARD, IN WRITING, OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.*